Iowa CACFP Adult Day Care Center Household Letter — Rev. 7/09

Dear: _____

Complete, sign and return the enclosed Income Eligibility Form as soon as possible. This form is necessary so that we may receive reimbursement for the meals served to you under the Child and Adult Care Food Program (CACFP). This form will be treated as confidential information. If you are unable to complete and sign the form, a guardian or household member may complete it. Your form must be completed as follows:

Food Assistance/SSI/Medicaid Households: If you currently receive Food Assistance or Supplemental Security Income (SSI) or Medicaid, you have to list your name and the case number and **Sign** the form.

OR

All Other Households: If your household is at or below the level shown on the Income Guidelines at the bottom of this page, you must provide the following information on the following pages or your form cannot be approved:

1. **Household Members:** List your name and the name of your spouse and/or any other people who live with you and depend on you for financial support. **If the people who live with you do not depend on you financially, then their names and income do not need to be included on this form unless you are married. If married, both spouses' names must be listed.**
2. **Social Security Number:** List the Social Security Number (SSN) of the adult household member who signs the form. If an adult signing this form does not have a SSN, print "NONE."
3. **Monthly Income:** List your monthly income by source **and** monthly income by source of all the people you live with who depend on you for financial support.
4. **Signature:** You or a guardian or a household member must sign the form. If you are unable to complete and sign the form, a guardian or household member must complete and sign it.

If you do not now qualify to receive free or reduced price meals, you may apply for benefits at any time during the year. If you are not eligible now and later have a decrease in household income, have an increase in family size or start receiving FS/SSI/Medicaid Benefits, you may become eligible.

❑ This center does not charge separately for meals.
❑ This center charges the following rates for meals:

Meal	Full Price	Reduced Charge
Breakfast		.30
Lunch/Supper		.40
Snacks		.15
If you do not agree with the center's decision about your application, you may wish to discuss it with them. You also have a right to a fair hearing. The can be done by calling or writing the following hearing official:_____ Contact information for hearing official:_____		

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2009 to 6-30-2010

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	20,036	1,670	835	771	386
2	26,955	2,247	1,124	1,037	519
3	33,874	2,823	1,412	1,303	652
4	40,793	3,400	1,700	1,569	785
5	47,712	3,976	1,988	1,836	918
6	54,631	4,553	2,277	2,102	1,051
7	61,550	5,130	2,565	2,368	1,184
8	68,469	5,706	2,853	2,634	1,317
For each additional family member add:	+6,919	+577	+289	+267	+134

Iowa CACFP Adult Day Care Center Income Eligibility Form (front) **Rev. 7/09**

Carefully complete this form, sign it and return it to the center

PART 1 - Complete Part 1 if you currently receive Food Assistance or Supplemental Security Income (SSI) or Medicaid. If you complete this part, skip Part 2 and go on to Part 3.

Name	Medicaid (Title XIX) Case No.	SSI Case No.	Food Assistance Case No.

PART 2 - Complete Part 2 if you have not completed Part 1.

Below, under **"Name"**, list your name and the names of your spouse and/or any other people who **live with you and depend on your for financial support.** If you need more space, use a separate piece of paper. In the last 4 columns, list **All** income received last month on the same line as the name of the person who received it. You must list the **gross** monthly income, (the amount **before** deductions for taxes, Social Security, etc.) List each amount under the correct source. If income is negative, it should be listed as **"zero"** income. If last month's income does not accurately reflect your circumstances, you may estimate the amount that you expect to receive each month. Income that changes from month to month, such as farm income, may be averaged over the previous 12 months.

Name (Last, First) Enrollee	Age	Salary/ Wages Before Deductions	Welfare, Child, Support & Alimony	Pensions & Social Security	All Other Income
1.		$	$	$	$
2.		$	$	$	$
3.		$	$	$	$
4.		$	$	$	$
5.		$	$	$	$
6 .		$	$	$	$
7.		$	$	$	$

If you did not give a Food Assistance, SSI, or Medicaid Identification Number, federal law (PL97-35) requires you to list the Social Security number of the adult household member signing this form before the adult day care center may receive reimbursement for meals served to you under the CACFP. You do not have to give the Social Security number, but if you refuse, the center cannot receive free or reduced price meals reimbursement. Verification may include audits, investigations, contacting the State Employment Security office, Food Stamp or Welfare office, employers, and checking the written information provided by you to confirm the information received. If incorrect information is discovered a loss of benefits or legal action may occur. These facts must be told to the household member whose Social Security number is reported on this form.

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PART 3 - Racial/Ethnic Data and Signature

Please check off the racial/ethnic group to which you belong. You are not required to answer this question. If you do not answer the question, someone at the center will make a determination. No one will be discriminated against because of rate, sex, color, national origin, age or handicap.

1. ❑ Hispanic or Latino ❑ Not Hispanic or Latino

2. ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native
❑ Asian ❑ Native Hawaiian or Other Pacific Islander

Penalties for Misrepresentation: I certify that all of the information on this form is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that the information given may be verified; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws. **You or a guardian or an adult household member must sign below.**

Signature

Address

Print Name

City

Social Security Number

State Zip Code

Date of Signature

Telephone Number

For Center or Sponsor Use Only

This form must be signed by center personnel and the Free, Reduced, or Paid category determined in order for this form to be valid. **This form is valid only for one year from the date below.**

Total Monthly Income (if applicable): $_____ **Family Size** _____

❑ Free (☐Food Assistance, ☐SSI, ☐Medicaid or ☐Income), ❑ Reduced, ❑ Paid (Ineligible for free or reduced price meals)

FOR ADMINISTRATIVE USE ONLY

Determining Official Signature Date

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.